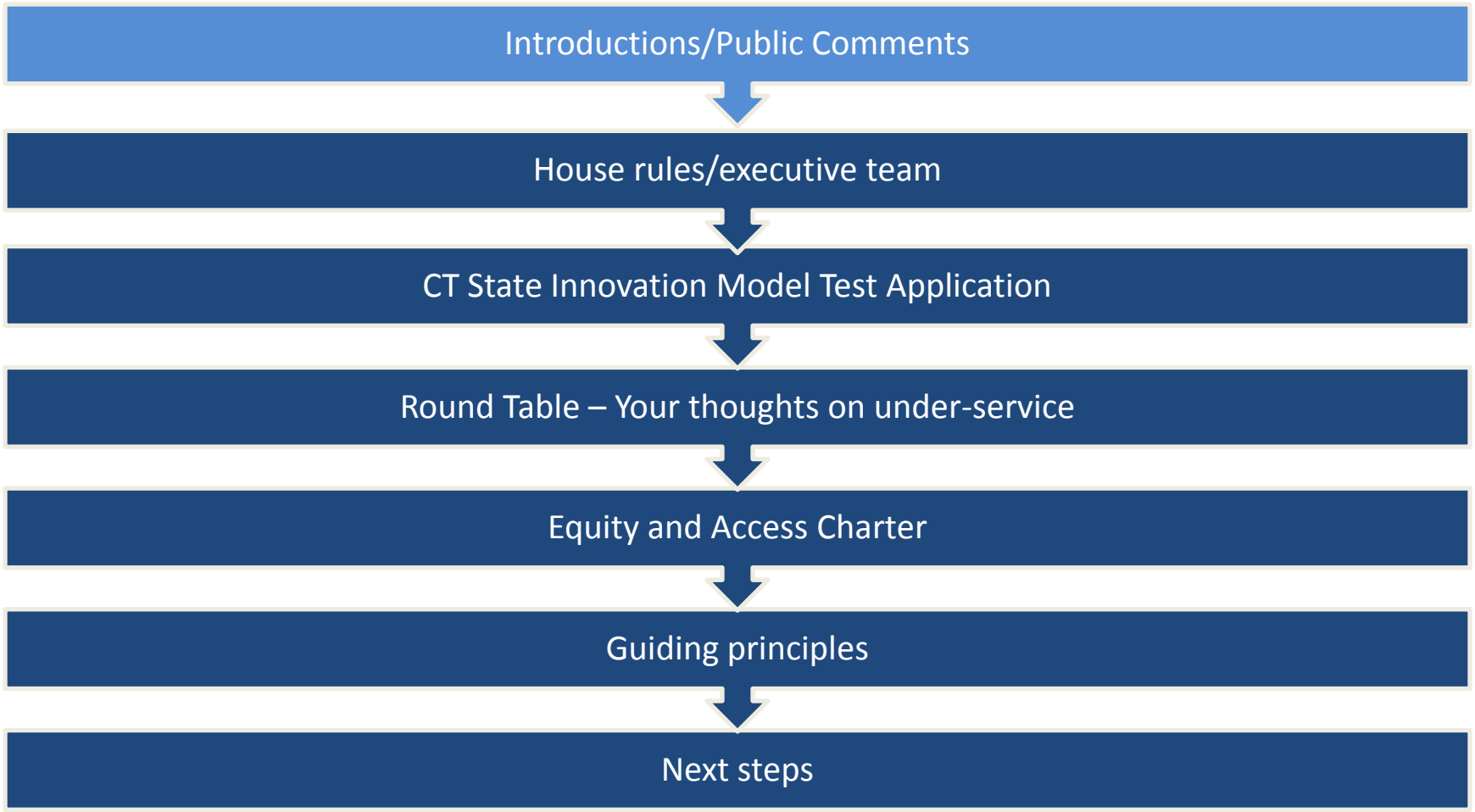
Equity and Access Council Meeting

July 24th, 2014

Agenda


Introductions/Public Comments
House rules/executive team
CT State Innovation Model Test Application
Round Table – Your thoughts on under-service
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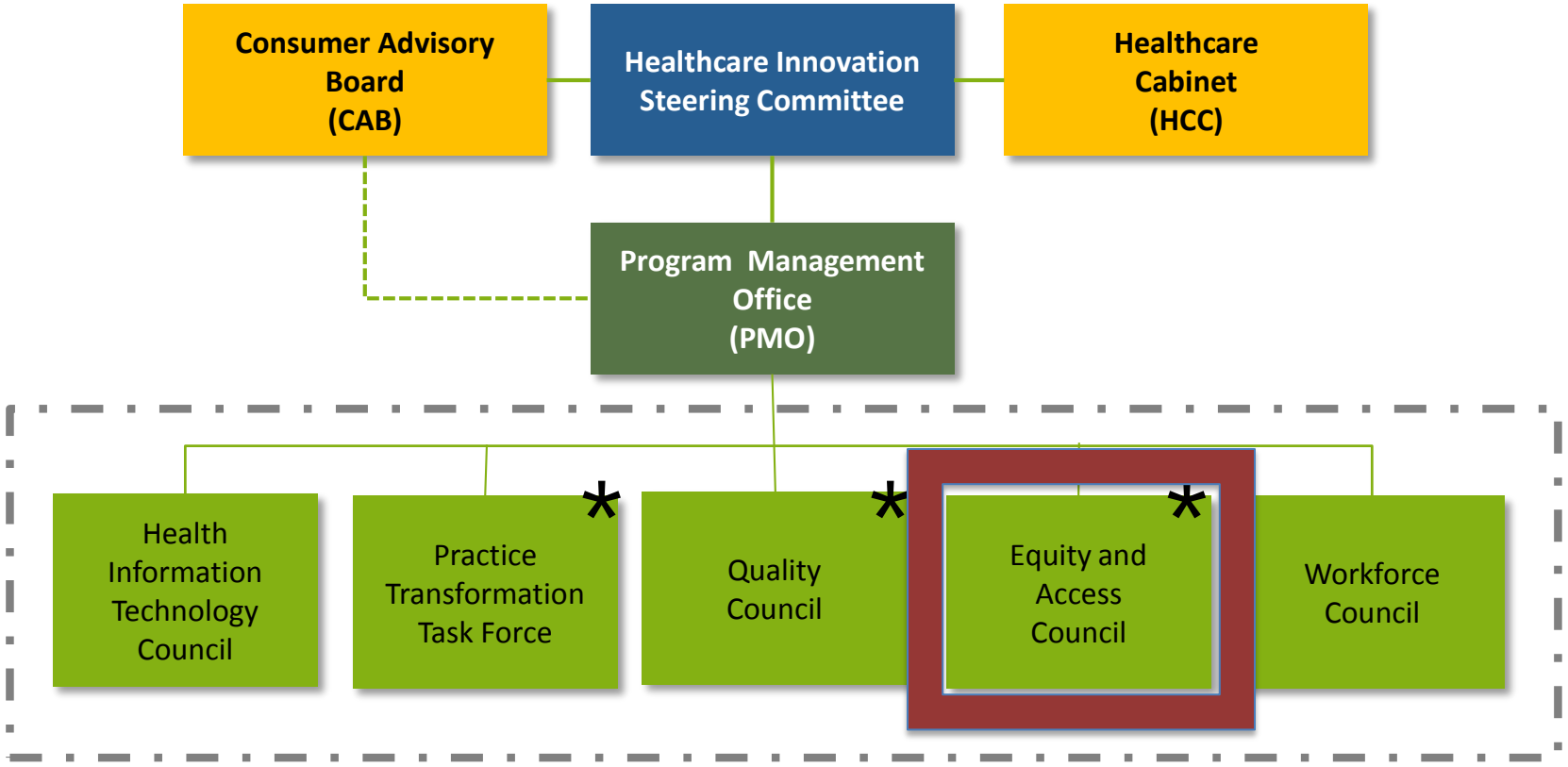
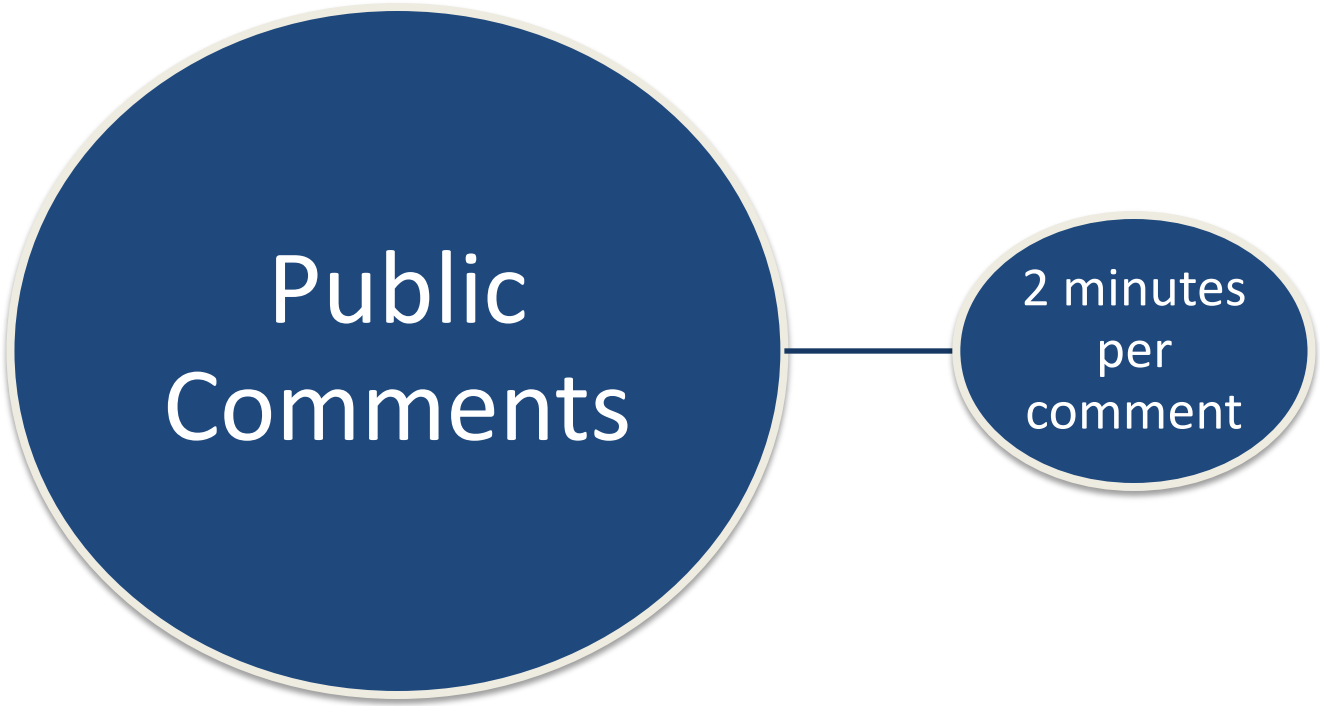
Next steps

SIM Governance Structure

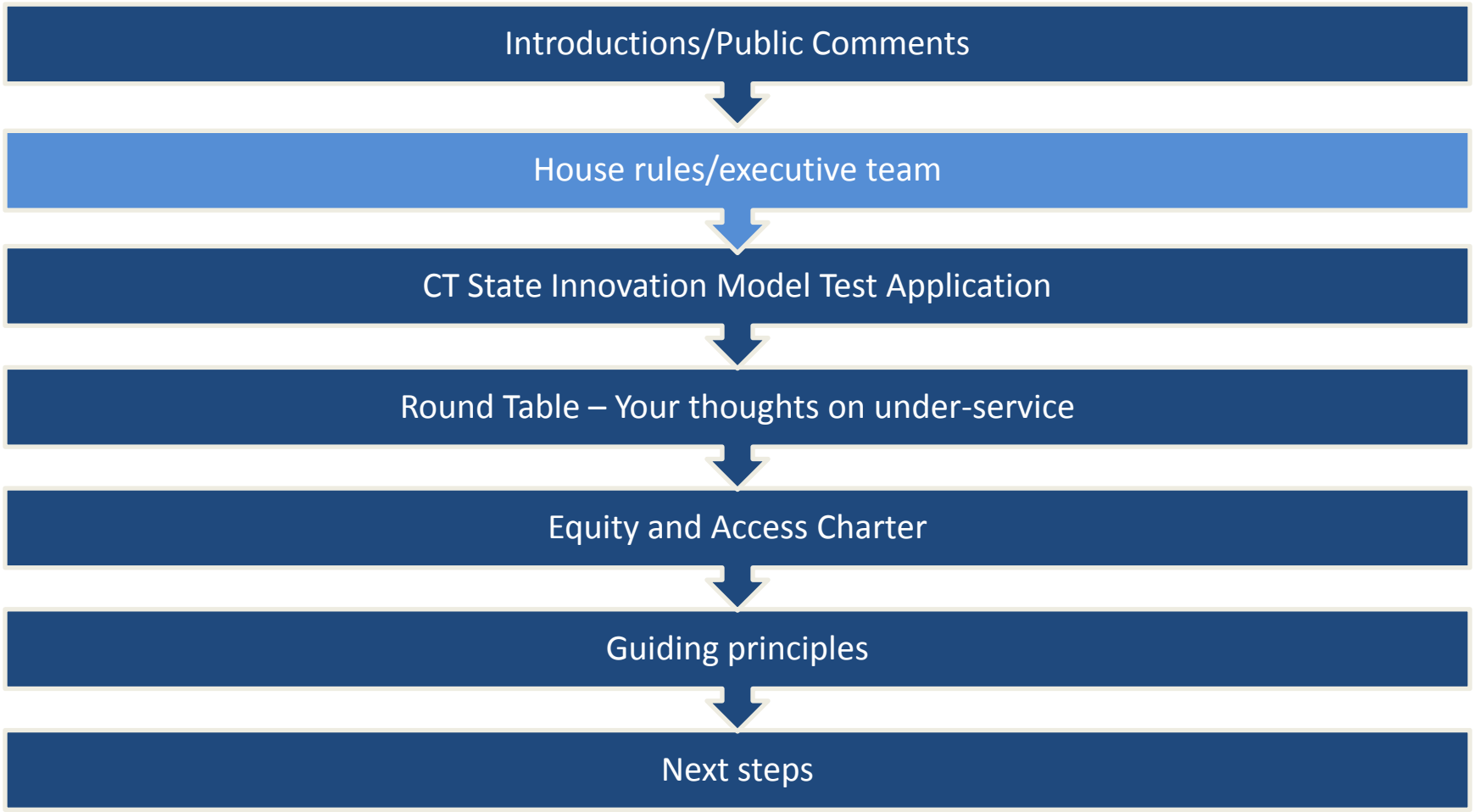


Welcome to the Equity and Access Council

Ellen Andrews, PhD *CT Health Policy Project*	Amy Lazzaro *Cigna*
Linda Barry, MD *UConn Health Center*	Roy Lee *Consumer/Advocate*
Maritza Bond *Eastern AHEC*	Kate McEvoy *Department of Social Services*
Peter Bowers, MD *Anthem Blue Cross Blue Shield*	Donna O'Shea, MD *UnitedHealthcare*
Darcey Cobbs-Lomax *Project Access*	Robert Russo, Jr., MD *Robert D. Russo MD & Associates Radiology*
Barbara Headley, DMin *Consumer/Advocate*	Erica Spatz, MD *Yale New Haven Hospital*
Margaret Hynes *Department of Public Health*	Keith vom Eigen, MD *Burgdorf Health Center*
Gaye Hyre *ArtBra New Haven*	Robert Willig, MD *Aetna*


Public Comments
2 minutes per comment

Agenda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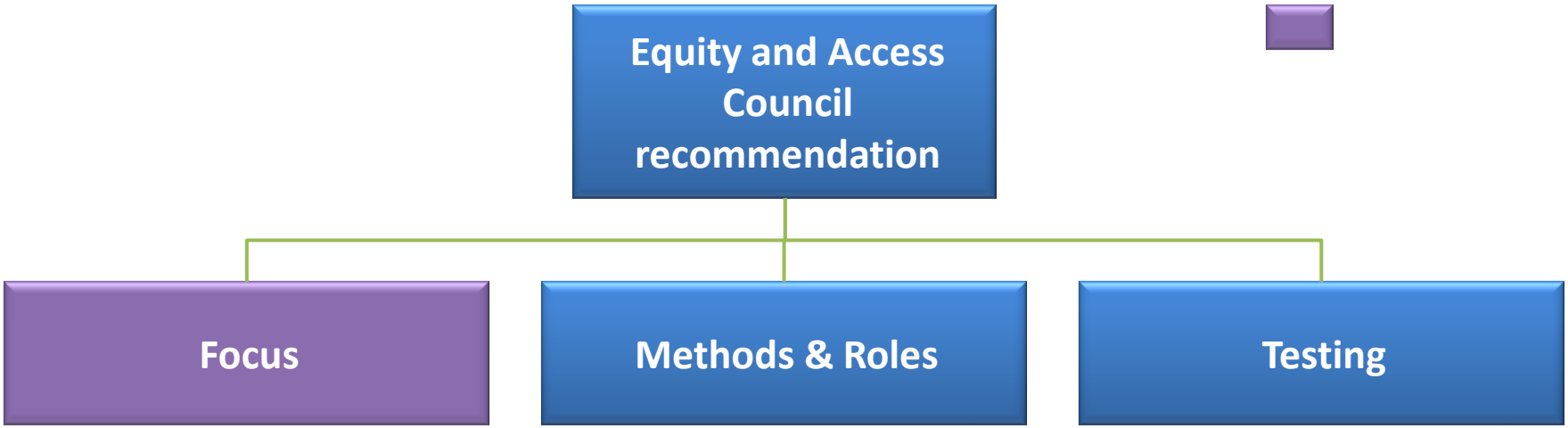
House Rules

- Expectations of taskforce members:
  - Presence
    - Attend meetings
    - Prepare and participate between meetings as needed to move issues along
  - Outlook
    - Leave jobs and titles at the door; focus on best interest of CT citizens
    - Look for consensus to make recommendations to PMO
  - Action
    - Find solutions for proposed questions
    - Build ideas and be proponent of change and transformation
    - Be vocal and share the importance of our mission

Equity and Access Council Roadmap



- What is under-service?
- What is patient selection?
- What risks should be our top priority?

- What methods are in use today?
- What methods do we recommend?
- What processes should be followed when under-service is suspected?
- What role should consumers, payers and providers play?

- What tests should be under-taken prior to implementation?
- What specific recommendations do we have for MQISSP?

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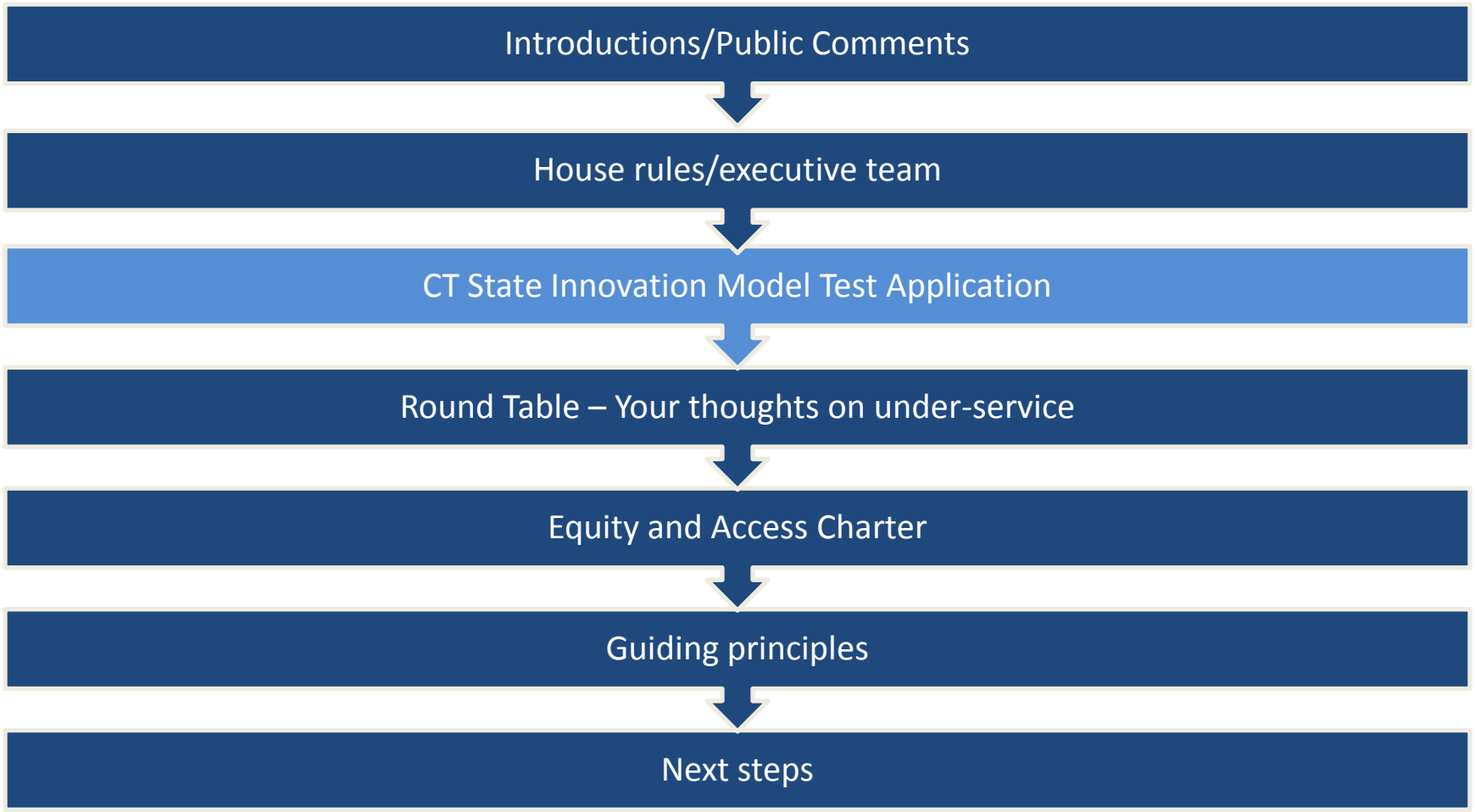
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State Innovation Model
Test Grant Application

Vision: Connecticut is seeking to establish a whole-person-centered healthcare system that improves population health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their healthcare; and improves affordability by reducing healthcare costs.

State Innovation Model
Test Grant Application

- Our Model Test drives accountability, consumer engagement and high quality of care through
  - development of a comprehensive evidence-based plan for improving population health;
  - initiatives to strengthen primary care and integrate community and clinical care;
  - value-based payment and insurance design; and
  - multi-payer alignment on quality, health equity, and care experience measures.

State Innovation Model
Test Grant Application

Statewide Interventions	Targeted Interventions
Plan for Improving Population Health	Medicaid QISSP
Quality Measure Alignment	Primary Care Transformation
SSP based on Care Experience/Quality	• Advanced Medical Home Program
Value Based Insurance Design	• Community & Clinical Integration Program
Workforce Development	• Innovation Awards
HIT / Analytics / Performance Transparency	• Learning Collaboratives

State Innovation Model
Primary Care Transformation

- Advanced Medical Home Glide Path (NCQA +)
- Community and Clinical Integration Program

  1) integrating behavioral health and oral health,

  2) providing medication therapy management services,

  3) building dynamic clinical teams,

  4) expanding e-consults between PCPs and specialists,

  5) incorporating community health workers,

  6) closing health equity gaps,

  7) improving the care experience for vulnerable populations,

  8) establishing community linkages

  9) identifying “super utilizers” for community care teams

State Innovation Model
Value-based payment

- Broadly aligned around the Medicare SSP
- Responsible for overall cost of care for their patients
- Rewarded with a share of any savings *if they meet quality and care experience targets*
- Goal is to create a practice culture that is organized around increasing value

$$\text{Value} = \frac{\text{Quality + Care Experience}}{\text{Cost}}$$

State Innovation Model
Shared Savings Program

- Project how much it should cost for provider to serve their patients for one year
- Similar to establishing an annual budget--actually a *virtual* budget, because provider *continues to be paid fee-for-service*
- Projected budget higher for consumers with chronic illnesses
- This is called risk adjustment

State Innovation Model
Shared Savings Program

- Although the provider is paid fee-for-service, the costs for their panel of patients are tracked relative to the projected budget
- Budget includes all costs of care including hospitalizations, lab/diagnostic imaging, and specialty care.
- Provider earns a share of the savings if the overall costs for their panel of patients for the year are less than was projected by the payer.

State Innovation Model
Shared Savings Program

- In some arrangements, providers returns funds if their costs exceed the projected budget. This is called a risk arrangement
- Providers will typically try to achieve savings by providing high quality care and more efficient care
- For example, if they improve their ability to quickly find the right diagnoses for a patient, and to provide the right care the first time so as to avoid hospitalizations
- However, they may also achieve savings by eliminating wasteful and duplicative services

State Innovation Model
Over- service

- Fee for service programs reward volume of services, even if those services are unnecessary or ineffective
- Sometimes these unnecessary services are costly or inconvenient or even harmful
- Most payers look at their claims data to identify providers who provide more services than are necessary
- They have program integrity or audit divisions that look for over-service

State Innovation Model
Under-service

- Shared savings programs create an incentive to provide only those services that are necessary and effective
- However, there are concerns that they might also create incentives to provide *fewer* necessary services
- This concern about under-service is the primary reason that this Council was established

State Innovation Model
Over- and Under-service

- Setting quality targets reduces the risk of under-service for target conditions
- However, they may not reduce the risk of under-service in the treatment of other conditions
- It could also lead to avoiding patients who are going to be harder than usual to treat…this is called “patient selection”

State Innovation Model
Focus on Value

- Benefits outweigh the risks
- *Flexibility* in service and a *culture* of value
- Safeguards – our unique contribution
- Reduce costs so that healthcare remains accessible and affordable

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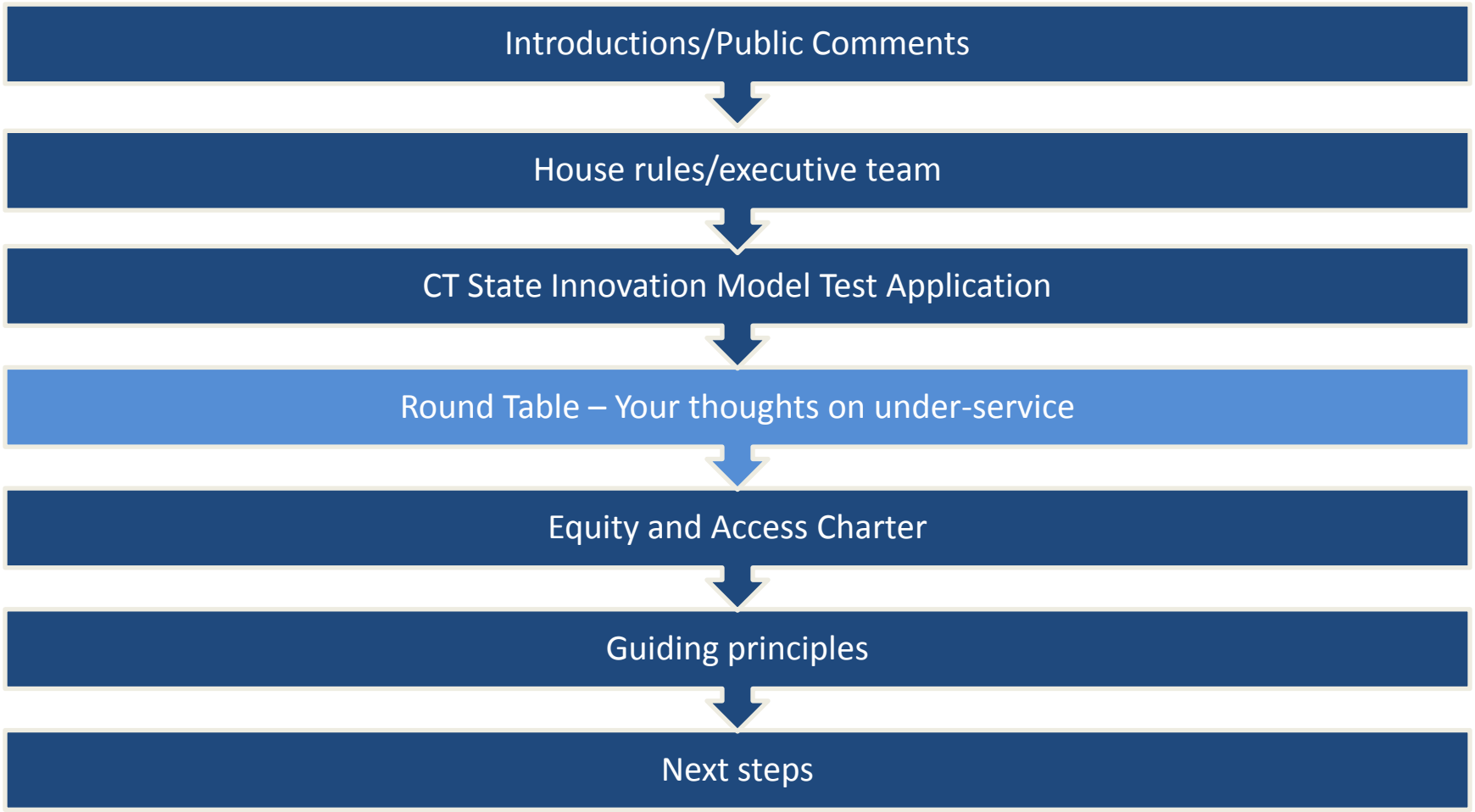
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Your thoughts on under-service

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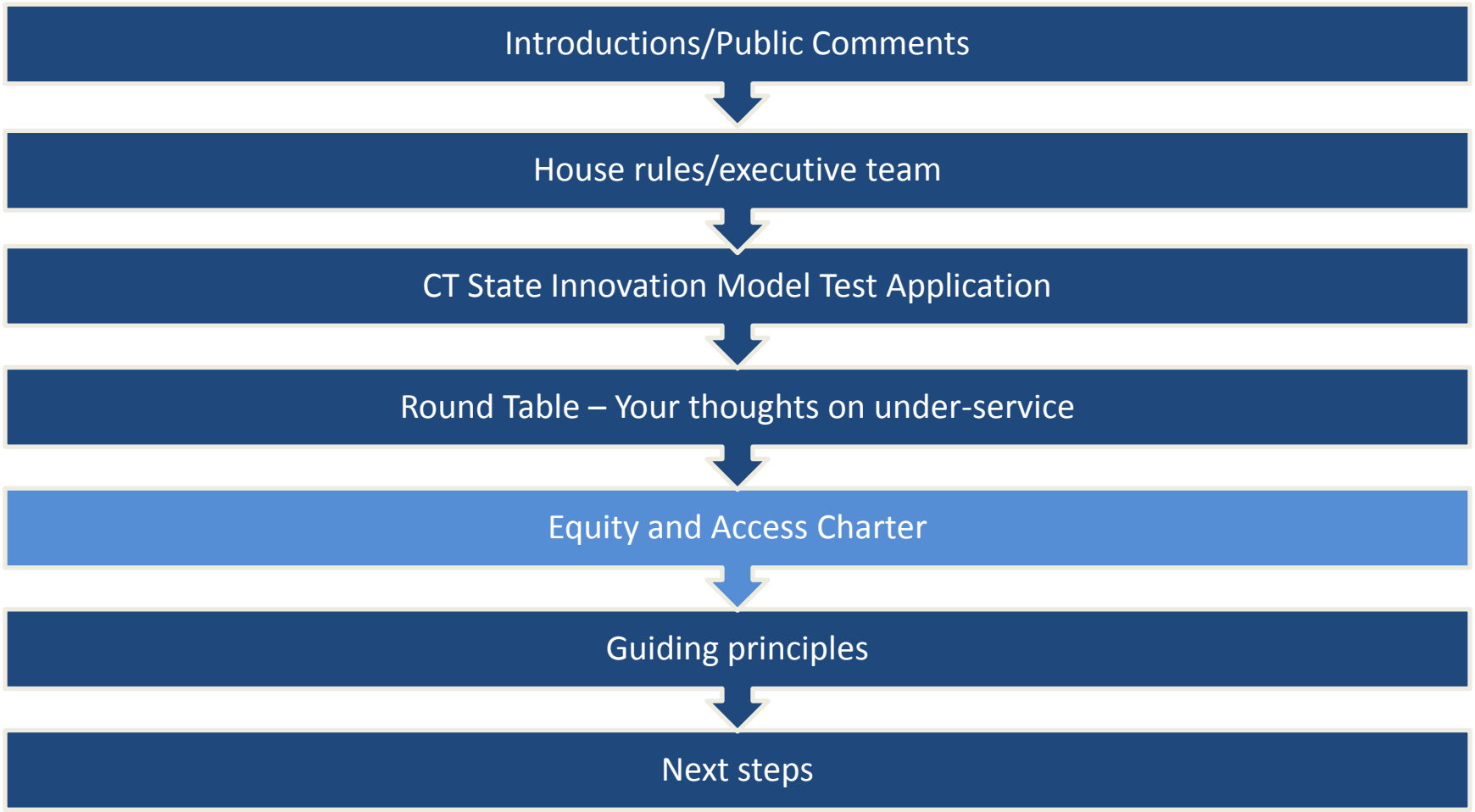
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Equity and Access Charter
Introduction

- Develop for recommendation to the Healthcare Innovation Steering Committee a proposal for:
  - retrospective and concurrent analytic methods to ensure safety, access to providers and appropriate services, and
  - to limit the risk of patient selection and under-service of requisite care;
  - recommend a response to demonstrated patient selection and under-service; and
  - define the state's plan to ensure that at-risk and underserved populations benefit from the proposed reforms.
- Identify key stakeholder groups whose input is essential to various aspects of the Council's work and formulate a plan for engaging these groups to provide for necessary input

Equity and Access Charter
Introduction

- Convene ad hoc design teams to resolve technical issues that arise in its work.
- Patient selection refers to efforts to avoid serving patients who may compromise a provider's measured performance or earned savings.
- Under-service refers to systematic or repeated failure of a provider to offer medically necessary services in order to maximize savings or avoid financial losses associated with value based payment arrangements. A finding of failure shall not require proof of intentionality or a plan

Equity and Access Charter
Context

- Equity includes assurance that underserved populations aren't subjected to targeted under-service and patient selection. Disparities in quality, outcomes, and care experience will be within the scope of the Quality Council plan

Equity and Access Charter

Assessing Risk

1. What evidence is available today regarding patient selection and under-service in total cost of care payment arrangements (e.g. ACO, shared savings plan)?
2. Have public or private payers undertaken studies to examine the risk of patient selection or under-service that could inform this council's work?

Equity and Access Charter

Guarding against under-service

1. What are the current methods utilized by private and public payers for detecting under-service?
2. Can standard measures and metrics be applied for the detection of under-service?
3. What are the program integrity methods in use today by Medicare / Medicaid and how might such methods be applied to detect under-service?
4. Who will monitor, investigate, and report suspected under-service and what steps should be taken if under-service is suspected?

Equity and Access Charter

Guarding against under-service

5. What are the criteria and processes that a payer might use to disqualify a clinician from receipt of shared savings due to demonstrated under-service?
6. What are the mechanisms for consumer complaints of suspected under-service?
7. Given the above, what is the Council's recommended approach for Connecticut's public and private payers to monitor for and respond to under-service?

Equity and Access Charter

Guarding against patient selection

1. What are the current methods utilized by private and public payers for monitoring of patient selection?
2. Can standard measures and metrics be applied for the monitoring of patient selection?
3. What are the program integrity methods in use today by Medicare / Medicaid and how might such methods be applied to detect patient selection?
4. What other methods might be available to monitor for patient selection (e.g., mystery shopper)?

Equity and Access Charter

Guarding against patient selection

5. Who will monitor, investigate, and report suspected patient selection and what steps should be taken if patient selection is suspected?
6. What are the criteria and processes that a payer might use to disqualify a clinician from shared savings arrangements due to patient selection?
7. What are the mechanisms for consumer complaints of suspected patient selection?
8. What is the recommended approach for CT's public and private payers to monitor for and respond to patient selection?

Equity and Access Charter

Potential questions for a later phase

1. Network adequacy, provider participation, Medicaid specialty care, timely and necessary services?
2. Care variations and standardization, evidence-based standards?

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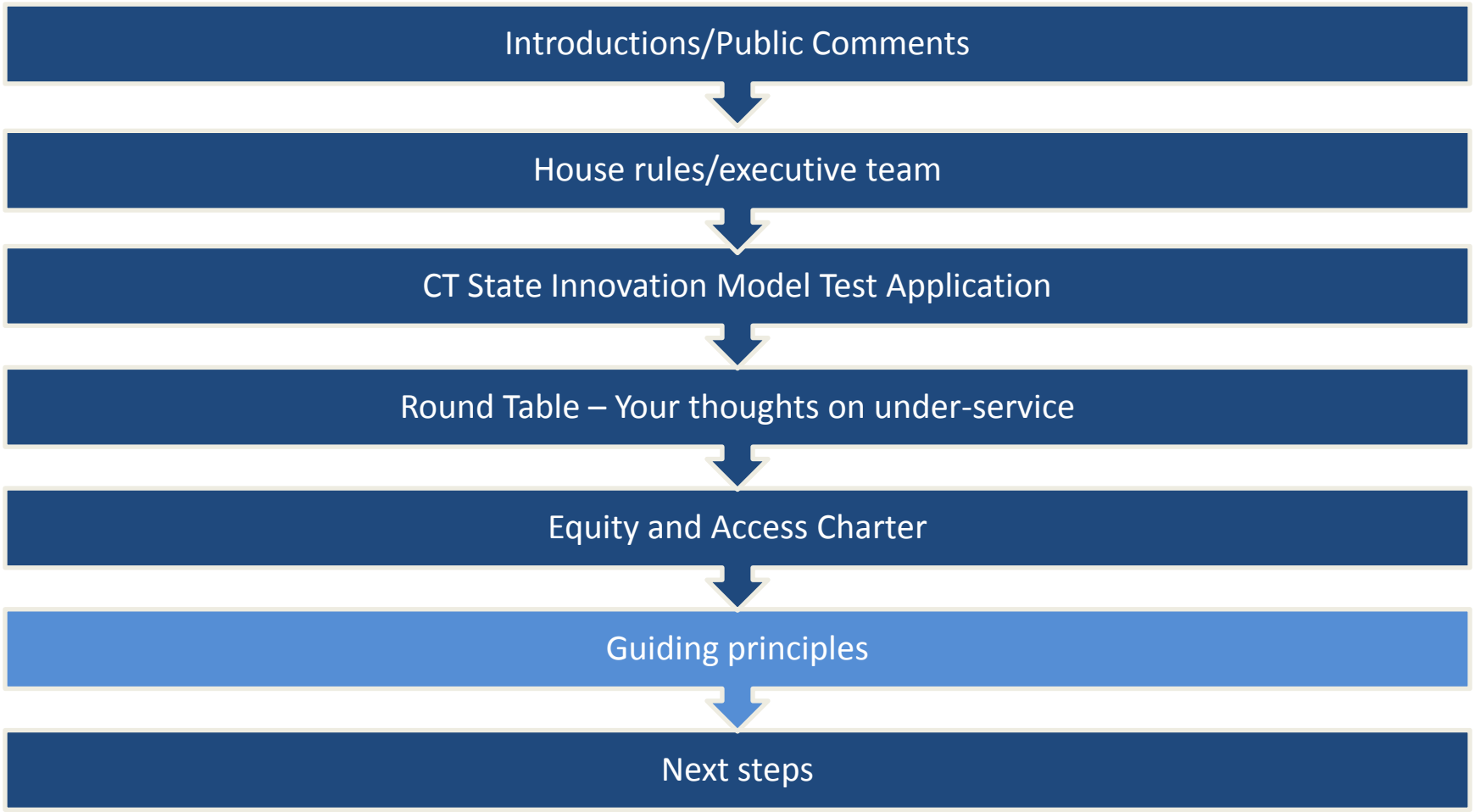
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Meeting Schedule